DOCUMENT RESUME

ED 044 011 EC 030 596

AUTHOR	Gardner, James M.
TITLE	Training Proficiency Scale (Form A) Manual.
INSTITUTION	Ohio State Inst., Columbus.
PUB DATE	Aug 69
NOTE	23p.
EDRS PRICE	EDRS Price MF-$0.25 HC-$1.25
DESCRIPTORS	Behavior Change, Evaluation Methods, *Exceptional Child Research, Mentally Handicapped, *Operant Conditioning, *Rating Scales, *Teacher Evaluation, Testing, *Training Techniques

ABSTRACT

The Training Proficiency Scale, designed to evaluate the competence of a trainer utilizing operant conditioning techniques with the mentally handicapped, is described in terms of its need, development, reliability and validity qualities, and four areas of assessment (shaping behavior, rewarding, communicating, and rapport). The scale is presented in its entirety, and instructions for scoring are provided. A glossary of terms used in behavior modification research with the mentally retarded is included. (RD)

ED030390

ED 044011

EC030596

ED044011

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

TRAINING PROFICIENCY SCALE
(Form A)

MANUAL

James M. Gardner

"PERMISSION TO REPRODUCE THIS COPYRIGHTED MATERIAL HAS BEEN GRANTED BY James M. Gardner

TO ERIC AND ORGANIZATIONS OPERATING UNDER AGREEMENTS WITH THE U.S. OFFICE OF EDUCATION. FURTHER REPRODUCTION OUTSIDE THE ERIC SYSTEM REQUIRES PERMISSION OF THE COPYRIGHT OWNER."

~~Columbus State Institute~~
~~1601 West Broad Street~~
~~Columbus, Ohio 43223~~

EC 030 596

LC030596

TRAINING PROFICIENCY SCALE
(FORM A)
MANUAL

James M. Gardner

Introduction..... 1
Development of the scale..... 1
Reliability..... 2
Validity..... 3
The rating session..... 3
Relevant publications..... 4
The Training Proficiency Scale.. 6
Instructions for scoring..... 8
Glossary.....19

Columbus State Institute
1601 West Broad Street
Columbus, Ohio 43223

This manual and rating scale were developed as part of the Columbus State Institute Behavior Modification Projects, Luke Watson, Ph.D., Coordinator. This project was supported by Hospital Improvement Program grant No. 1 P20 MR 02119-01 and Hospital Inservice Training Program grant No. 1 T10 MR 05116-01. The author wishes to acknowledge the assistance of Donna Brust, Roy Shapiro, and Stanley Solomowitz.

No part of this manual or rating scale may be reproduced in any form without the permission of the author.

August 1969

INTRODUCTION

The modification of the behavior of the mentally retarded through the systematic application of operant conditioning techniques has become an area of increasing concern. Within the last three years, since 1966, more than seventy percent of the literature in the field has appeared. Behavior modification programs are common in state schools for the retarded, state hospitals, special education classes in the public schools, and elsewhere throughout the United States. Behavior modification techniques have been applied to a broad range of problems, including habit training, recreation, language, education, social skills, audiometry, and others.

While there appears to be a large amount of research and clinical practice in the area of behavior shaping with the mentally retarded, almost all the attention has been given to outcome variables. To date, there has not been a single attempt to systematically study the effectiveness of various teaching methods nor has there been an attempt to assess competence in using behavior modification techniques.

The Training Proficiency Scale was designed to fill this deficiency. Its major purpose is to provide a useful, reliable, and valid measure of competence in using behavior modification techniques. Other constructive uses of the scale are as a screening device, a dependent variable in evaluating the success of training programs, and for periodic evaluation of personnel.

Development of the Scale

The Training Proficiency Scale (TPS) was developed as the result of extensive meetings with personnel experienced in behavior modification techniques. The purpose of the meetings was to isolate the important component behaviors which

constitute "behavior modification skills". Four broad areas emerged: (1) shaping, (2) rewarding, (3) communicating, and (4) rapport. A fifth area was designated miscellaneous.

Definitions of these areas are given below:

SHAPING:	Analyzing complex behavior into simpler components and then teaching the simpler parts a step at a time until the complex behavior has developed.
REINFORCING:	Giving social, physical, or edible rewards. A reinforcement is something that a person likes and will expend effort to obtain.
COMMUNICATING:	Giving instructions in such a way as to maximally facilitate understanding.
RAPPORT:	Becoming acquainted with the child so that he will approach you and be more amenable to your instructions.

After defining each of the areas, component behaviors were derived. This list of behaviors was then reviewed with certain items being added and others eliminated. A total of 26 items constituted the first version of the TPS. This was then piloted with a group of ten trainers, and subsequently revised. The current version of the TPS (Form A) contains 30 items and is included in appendix A.

Reliability

Interscorer reliability was obtained by having two graduate students in developmental psychology independently rate ten trainers. No manual of instructions was provided nor was there an opportunity to establish scoring conventions. Nonethe-less the correlation coefficient was .89. Interscorer reliabilities for each of the four areas based on these records were: .82 (shaping), .82 (reinforcing), .78 (communicating, and .65 (rapport and miscellaneous).

Split half reliability based on ten protocols using the odd-even method was .97 (uncorrected).

Test-retest reliability based on re-rating seven trainers after a period of one week was .86.

Validity

The correlation between TPS scores and scores on a true-false test of knowledge of the principles of behavior modification was .89. This can be given as support for the construct validity of the test, since skill in using behavior modification techniques should be related to knowledge of the field.

As a measure of the concurrent validity of the TPS, two experienced raters made global evaluations of ten trainers following rating sessions. Trainers were rank ordered in terms of overall competence without regard to the TPS scores (which had not been totaled). The correlation between TPS scores and overall evaluations was .96 and .84 for raters one and two respectively.

Since this measure is open to criticism due to the confounding of the criterion with the predictor, a third judge observed the rating sessions but did not rate nor confer with the raters. His rank orderings correlated .93 and .94 with the rank orderings by raters one and two respectively. The correlation between the judges rank orderings and TPS scores for raters one and two were .98 and .88 respectively. It can be seen that TPS scores accurately reflect judgements of overall competence.

The Rating Session

Rating sessions average 15 minutes. Trainers can be rated in a role-playing situation or actually working with residents. In the role-playing situation, two trainers alternately act as trainer or patient. One advantage of

using role-playing is that it allows for a wide variety of behaviors which might otherwise not show up in a session with a child. On the other hand, role-playing is not the same as working with a resident and there are potential differences which might obscure good or bad training techniques. We have found, from our experience, that TPS scores on role-playing were highly correlated with scores on working with residents (r = .87).

To be sure that all relevant training behaviors have been exhibited, it is sometimes necessary to offer a hypothetical problem to a trainer for solution. For example, if the resident has not misbehaved during the session, the rater might ask "What would you do if the patient began screaming?" This way complete records on every trainer for every behavior can be kept.

Gardner, J. M. Behavior modification in mental retardation: A review of research and analysis of trends. In R. Rubin and C. M Franks (Eds.) Progress in behavior therapy, 1969. New York: Acadmeic Press, 1970. inpress.

Gardner, J. M., Brust, D. J., and Watson, L. S. A scale to measure proficiency in applying behavior modification techniques. American Journal of Mental Deficiency, 1970, inpress.

Gardner, J. M. and Watson, L. S. Differential effectiveness of two instructional methods for teaching behavior modification techniques to institutional attendants Paper, 93rd annual AAMD, Washington, 1970.

Solomowitz, S. Assessment within a behavior modification framework. Paper read at second annual Gatlinburg Conference on Mental Retardation, Gatlinburg, Tennessee March, 1969.

Appendix A

TPS

COLUMBUS STATE INSTITUTE/BEHAVIOR MODIFICATION PROJECTS JULY 1969

TRAINING PROFICIENCY SCALE
(FORM A)

PURPOSE: To evaluate proficiency in using operant conditioning techniques.

INSTRUCTIONS: For each item rate the trainer on a five point scale: 1 = very poor, 2 = poor, 3 = average, 4 = good, 5 = very good. If an item cannot be rated, score NA.

TRAINER_____PATIENT_____RATER_____DATE_____

A. SHAPING BEHAVIOR

		NOTES	- RATING
1.	Gets the subject's attention.		
2.	Determines the operant level.		
3.	Demonstrates the desired behavior.		
4.	Starts with the correct step.		
5.	Uses the proper sequence of steps.		
6.	Proceeds to the next step appropriately.		
7.	Returns to previously successful step if necessary.		

B. REWARDING

8.	Finds an effective reward.		
9.	Gives the reward quickly.		
10.	Gives verbal reward enthusiastically.		
11.	Gives verbal reward with primary reward.		
12.	Gives physical reward enthusiastically.		
13.	Gives physical reward with primary reward.		
14.	Uses the bridging signal in chaining.		
15.	Changes the reward if necessary.		
16.	Withholds reinforcement correctly.		
17.	Gives reinforcement correctly.		

C. COMMUNICATING

18.	Uses the correct emphasis in commands.		
19.	Uses correct verbal commands.		
20.	Uses patient's name before command.		
21.	Gives correct gesture.		
22.	Uses physical prompts effectively.		
23.	Fades physical prompts correctly.		
24.	Fades gestures correctly.		

D. RAPPORT AND MISCELLANEOUS

25.	Gets acquainted before training.		
26.	Shows adequate patience during training.		
27.	Handles children respectfully.		
28.	Properly ignores inappropriate behavior.		
29.	Prepares room correctly before training.		
30.	Trains one task at a time.		

(J.M.GARDNER)

Appendix B

Instructions for Scoring

Appendix B

Instructions for Scoring

TRAINING PROFICIENCY SCALE

Instructions for Scoring

A. SHAPING BEHAVIOR

1. Gets the subject's attention.

Prior to giving a command, simple or complex, it is necessary for the subject to be paying attention to the trainer. Otherwise the command will be wasted. An attempt must be made to find an effective method to obtain and hold the person's attention. Several methods may be used: calling his name, clapping your hands or snapping your fingers, showing the reinforcements, etc.

POOR	GOOD
An example of a poor training technique to gain attention would be to call a name in a low voice, or to give a command while the person is walking around the room or attending to other objects.	*Good trainers use effective methods to gain attention. The patients usually stop what they are doing and listen for the command. Eye contact is a good indicator that the person is attending.*

2. Determines the operant level.

At the beginning of a training session (before any skill is taught) it is to the trainer's advantage to determine the operant level. For example, if a child knows how to remove a pullover shirt and does this on command, it would be very time-consuming and unnecessary for the trainer to go through the various teaching steps. However, if the trainer has been told that this particular child can take off his shirt and he does not, the usual routine of training may be necessary -- apparently this person is not under verbal control, which is necessary in teaching new behavior.

POOR	GOOD
Poor trainers often neglect determining the operant level for many skills. They proceed to teach every skill to every person whether he knows it or not.	*A good trainer determines the operant level for all skills which he plans to teach. This is done before demonstrating the desired behavior, and with a minimum of cues or prompts.*

3. Demonstrates the desired behavior.

In order for a child to learn a new behavior it should be clearly demonstrated to him. The trainer, in teaching taking off a shirt, must remove the shirt for the child while he is repeating the command "Johnny, take off your shirt!" emphasizing the word "off." The trainer must be certain that the patient sees the desired behavior and hears the correct command before he can be expected to repeat the task.

POOR	GOOD
A poor trainer goes too fast and does not demonstrate the behavior. Often they do not wait until the person is attending before they demonstrate the particular behavior.	*Good trainers demonstrate the desired behavior simultaneously giving the command and rewarding the child. They wait until the patient is attending before demonstrating.*

4. Starts with the correct step.

This immediately follows the demonstration of the desired behavior. The first step taught is the last component step done, ie., the act which completes the behavior. When putting on a T-shirt, for example, the last component of the skill is pulling the hem of the shirt down to the waist. This, then, is the first step to teach and should be followed immediately with a reward. Of course, the first step will be dependent on the individual's level of ability and previous training.

POOR	GOOD
Poor trainers often begin at the wrong step, which is either too difficult or too easy for the patient.	*A good trainer begins at the correct step and proceeds from there.*

5. Uses the proper sequence of steps.

Progress is made faster if the proper sequence of steps is followed. In addition, training by more than one trainer is made possible when similar training procedures are followed. For any skill or behavior there are many components. Teaching each one successively increases the child's chances of succeeding and learning usually occurs much faster. It is important to gauge how large the step increments should be for any person.

POOR	GOOD
A poor trainer treats every person the same. No consideration is given to changing the size of the step increments. Often he forgets the proper order of steps.	*A good trainer uses the proper sequence of steps and adjusts them according to the individual needs of each patient.*

6. Proceeds to the next step when the subject is ready.

After the patient has learned the first step of any skill and is able to repeat the step without a physical prompt, he is ready to advance to the next step. This next step will depend on the person's ability to learn and his present repertoire. For example, while one child may be able to throw a ball after a few attempts, another may have to advance to throwing slowly. (ITEM NO. 6 differs from the previous item in that here the rater should be concerned with the proper <u>timing</u>, while in ITEM NO. 5 the emphasis is on the <u>knowledge</u> of the steps involved)

POOR	GOOD
The poor trainer usually proceeds too fast or too slowly, and his patients either fail or become distracted.	*A good trainer proceeds at an effective pace. His patients make steady progress in learning each new skill.*

7. Returns to previously successful step if necessary.

Three areas should be considered if a patient has learned one step after another and then suddenly will not follow through with the next step: (1) Is the reinforcement strong enough? (2) Is the person feeling well? (3) Has the person's tolerance level in this session been reached. A fourth possibility is that the particular step increment is too large for the person to succeed. If this is the case, the trainer should return to a previously successful step (the one immediately preceeding the failed step), allow him to repeat it, reward him, and then proceed to the next step, perhaps using smaller increments this time.

POOR	GOOD
Poor trainers often fail to return to earlier steps and continue to command the person despite continuing failures.	*A good trainer will return to a previously successful step when other possibilities for poor performance have been ruled out.*

B. REWARDING

8. Finds an effective reward.

The importance of finding an effective reward is obvious. The more effective a reward is, the more a child will work for it - in fact, the measure of a reward's effectiveness is the effort which a person puts out to get it. In the beginning of a training session primary reinforcements are usually the most effective forms of rewards. Later social reinforcement can be substituted.

POOR	GOOD
Poor trainers usually use the same rewards with all patients and don't experiment until they find the most effective one.	*The good trainer usually has a number of different rewards ready to find the most effective one. He usually determines this before he starts training.*

9. Gives the reward quickly.

Learning requires that the response and the reinforcement occur in close temporal proximity - that is, they occur closely together. This means that the reward should follow the desired response as quickly as possible - one to two seconds is a good estimate.

POOR	GOOD
A poor trainer usually fumbles with the rewards, dropping them, forgetting to give them, and giving them slowly.	*Good trainers usually have their rewards close at hand and give them quickly and smoothly.*

10. Gives verbal reinforcement enthusiastically.

Retarded children experience little success, so accentuating what success they do make is important. Verbal reinforcement (eg, "Good boy") should be given in a dramatic fashion. It must also be given in conjunction with the primary reinforcement (food) and serves as a "bridging signal" between the response and the reward. In other words, it is sometimes difficult to give the primary reinforcement immediately after the response; however, it is almost always possible to praise the child. This way, verbal praise becomes associated with the primary reinforcement and later can be used in its place.

POOR	GOOD
The poor trainer is apt to forget to give verbal reinforcement, or gives it in a mechanical manner.	*Good trainers have a flair for dramatics. Verbal praise is given with changes in loudness and tone, with much inflexion.*

11. Gives verbal reinforcement with primary reinforcement.

As was said above (ITEM NO. 10) it is important that verbal praise be given immediately after the response, and thus can serve as a bridging signal. Verbal praise can then be used instead of treats since it has been associated with them in the past. This is an important step in the child's development because it represents the acquisition of a basic receptive vocabulary.

POOR	GOOD
Poor trainers often forget to give praise, or if they do, the delay between praise and the treat is too long. Sometimes the praise follows the treat instead of coming before it.	*Good trainers give praise immediately after the desired response and before the treat.*

12. Gives physical reinforcement enthusiastically.

Most retarded children like physical contact (though there are exceptions). For most children it is very effective to give physical reinforcement by patting them softly on the back, rubbing their backs, giving them a short swing, etc. Like verbal reinforcement, it should be given with the primary reinforcement. In short, you try to reward the child in as many ways as possible at the same time, with a treat, by praising him, and with physical contact. Always, individual differences between children must be taken into account.

POOR	GOOD
Poor trainers often forget to give physical reinforcement, or give it mechanically.	*A good trainer gives physical reinforcement initially following every desired response.*

13. Gives physical reinforcement with primary reinforcement.

As in the case of praise (ITEM NOS. 10 & 11) it is important that physical reinforcement be associated with the primary reinforcement. In those cases where the physical contact is already reinforcing to the child this presents no problem. In cases where the child is afraid of physical contact, association with primary reinforcements is essential. Without physical contact, training is very difficult, and adjustment to everyday life situations is impossible.

POOR	GOOD
Poor trainers often forget to give physical reinforcement, or the delay between the physical contact and the treat is too long.	*Good trainers give physical contact immediately after the desired response, and in conjunction with praise. Both are given before the treats.*

14. Uses the bridging signal in chaining.

Once a child is responding to verbal praise, it can be substituted for treats. In a simple task, like asking a child to sit down in a chair on the other side of the room, one can first ask the child to "Come to me" then give him praise ("Good boy") followed by the next command "Sit over there" (pointing to the chair) and then give the treat for the completed response. This chain looks like:

"COME TO ME" - - - - - "SIT OVER THERE"
"Good Boy" *"Good Boy"plus treat*

Here the verbal praise has been used in a situation which before had required the treat. Of course, the time to begin using praise in establishing chains of responses will differ with each child.

POOR	GOOD
Poor trainers will begin using praise in chaining too early or too late. Sometimes they never even use it.	*Good trainers use praise and ubstitute it once responses have been well established. Usually the child reacts normally to this change when it is introduced correctly.*

15. Changes the reward if necessary.

Sometimes in the middle of a training session the child becomes increasingly distractible and stops working. There may be a number of causes for this (ITEM NO. 7), one of which may be that the reward is no longer effective. Retarded children, like the rest of us, become tired of the same thing - this is called satiation. If this is the case, a variety of rewards should be tried.

POOR	GOOD
Poor trainers usually don't remember this important variable and end a session before considering it.	*Good trainers take all of the possible reasons for poor performance into consideration.*

16. Withholds reinforcement correctly.

It is important to decide what the desired response will be before starting. This way it is clear what responses will be rewarded and which will not. For example, in taking off a pullover shirt, the first response may be holding the shirt. When the child does this he is rewarded. The next response would be holding the shirt and pulling it off the end of the arm. Now the child is not rewarded for just holding the shirt. Reinforcement must be withheld until the desired response occurs. If it does not, it is usually appropriate to say to the patient "No" and then repeat the command. Removing the reward from his sight with the word "No" is often effective. As always, you should be sure that the step which you are requiring is not too great for the child.

POOR	GOOD
Poor trainers are hesitant to withhold rewards. Often they forget to say "No" or to remove the reward from sight when the child is not responding appropriately.	*Good trainers correctly withhold the reward when the child doesn't respond correctly. They always in form him by saying "No" and removing the reward from sight momentarily.*

17. Gives reinforcement correctly.

Of course, it is vital that reinforcement be given correctly. A child is rewarded when he emits a desired behavior. As has been said there are individual differences between children and in the same child from time to time. This means that the trainer must be flexible and selecting the desired response, and must be ready to adjust that response to the conditions of the training session. Nonetheless, the child must be rewarded for desired responses, and must not be rewarded for undesirable behaviors. A trainer should be able to justify each reward given a child according to the goals of a particular training session.

POOR	GOOD
Poor trainers sometimes reward inappropriate behaviors, or they forget to reward the appropriate responses.	*A good trainer knows what responses to expect and rewards them when they occur. He does not reward inappropriate or undesirable behaviors*

C. COMMUNICATING

18. Uses the correct emphasis in commands.

It is often difficult for retarded children to understand words. There may be little difference for the child between the words "Take off your shirt" and "Put on your shirt." For this reason it is beneficial to emphasize certain important words. For example, one would want to emphasize the action words "off" and "on" in the above case.

POOR	GOOD
Poor trainers generally speak in a mechanical manner not emphasizing any words in particular, or they emphasize the wrong words - "Take off your shirt."	*Good trainers have that dramatic flair and use it to accentuate the important words in each command.*

19. Uses correct verbal commands.

In order to allow different trainers to work with the same child and not create difficulties in transfer of training, a standard language should be used. This makes it much easier for the patient. For example, if one trainer says "Take off your shirt" while another says "Give me your blouse" the child is likely to get confused.

POOR	GOOD
Poor trainers often use different commands during the same training session.	*Good trainers generally use a standard language in all situations with all children; however, they will vary the language when it becomes necessary.*

20. Uses patient's name before command.

Not only is it important to use the proper standard language emphasizing the important words, but it is also necessary to introduce commands with the patient's name. This is one effective way of getting his attention. Otherwise the command is wasted since it may have been completed before the child was listening. This also can serve as an important learning process for the child, where every command reinforces a rudimentary self-concept. Initially it is sometimes necessary to train a child to respond to his own name.

POOR	GOOD
A poor trainer often makes the mistake of putting the child's name after the command.	*Good trainers always use the child's name first.*

21. Gives correct gesture.

Sometimes it is not enough to give a retarded child a command. When commands are not sufficient they should be accompanied by gestures. If you are asking Johnny to "Come to me" and he has not responded to the verbal command, it is helpful to use your arms and hands and gesture. This is particularly useful when working on dressing skills and you are using the same word (shirt, pants) in giving commands which may call for opposite actions (off, on). It is very important that the gesture be given simultaneously with the command.

POOR	GOOD
Poor trainers either do not use gestures or use them incorrectly. Sometimes they are given after the command, or they are not sufficiently dramatic to be effective.	*A good trainer first determines whether a gesture is necessary, and if so, uses it correctly, simultaneously with the command, and with sufficient dramatization.*

22. Uses physical prompts effectively.

When commands plus gestures have not worked, and the child is still not obeying a simple command, it may be necessary to physically move the child's body and limbs, then reinforce him. In asking a child to "Sit down" you may at first have to sit him down by pushing down on his shoulders. Similarly, in dressing, an occasional move of his arm may be necessary to get a child started.

POOR	GOOD
A poor trainer uses physical prompts incorrectly by too much or too little emphasis. Sometimes they do not even use them at all.	*Good trainers use physical prompts when commands and gestures have failed. They use sufficient emphasis to produce the behavior without irritating the child.*

23. Fades physical prompts correctly.

Physical prompts may be necessary to initiate a skill but they are rarely necessary for long periods of time. In addition, they may be time-consuming. The sooner a physical prompt is eliminated the faster training progresses. Physical prompts are correctly faded by gradually reducing the physical assistance given by the trainer. Initially it may be necessary to put both arms on Johnny's shoulders to sit him down; then, maybe one arm. Later it may be enough to put your arm to hisshoulder to get him to sit. It is very important that the physical prompts be removed gradually.

POOR	GOOD
Poor trainers usually do not fade physical prompts, but rather stop using them abruptly.	*A good trainer gradually fades the physical prompt providing a smooth transition.*

24. Fades gestures correctly.

Once physical prompts have been faded, and the child is respo ding consistently, gestures can also be eliminated. Remember, the goal is to have the child under verbal control. As with physical prompts, gestures are not simply dropped, they are gradually reduced. Usually this amounts to going from large movements to smaller movements.

POOR	GOOD
Poor trainers usually stop the gestures abruptly.	*Good trainers gradually decrease the size of gestures.*

D. RAPPORT AND MISCELLANEOUS.

25. Gets acquainted before training.

A training session is an intimate interpersonal relationship between the patient and trainer. This is important to keep in mind. Much of the success in training will be related to the feeling which the patient has toward the trainer. Since the training session may be new to a patient, you should first become acquainted with him. What's his name? Let him walk around the room. Touch him. Let him touch you. Once the child is relaxed in the situation, you can begin training.

POOR	GOOD
A poor trainer begins training as soon as the patient enters the room.	*Good trainers take time to get acquainted before training. The first session may be devoted only to this.*

26. Shows adequate patience during training.

A training session can be a very tiring experience for the trainer as well as the child. Sometimes everything goes well, and sometimes it doesn't. When it doesn't, the trainer often becomes irritable and looses patience with the child. He may begin demanding too much, too soon, or too often. He may start raising his voice or otherwise indicate that he is loosing his patience.

POOR	GOOD
Poor trainers often loose their patience and become irritated.	*A good trainer stays calm in most situations, and if he looses his patience, he knows it is time to end the session.*

27. Handles children respectfully.

Retarded children are like any other human being and deserve to be treated with respect. Respect can be shown in various ways: in your voice, in the way you touch a child, in the things you say to him, etc. Pushing or shoving a child, referring to him in derogatory names, yelling, etc. are indications of a lack of respect for the patient as a person.

POOR	GOOD
A poor trainer is likely to call a patient names, dislike touching him, etc.	*Good trainers treat a patient as another human being.*

28. Properly ignores inappropriate behavior.

Often in a training session a child responds negatively. He may misbehave in a variety of ways: by throwing objects, screaming, banging his head, spitting, soiling himself, etc. It is usually best to ignore this behavior because paying attention might reinforce him, and the behavior would continut. In a short while the patient learns that treats are available and he can get them if he behaves and he won't get them if he misbehaves. This item should not be confused with ITEM NO.16 (Correctly withholding reinforcement). In ITEM NO. 16 the b havior is goal-direc ted by is not sufficient to warrant a reward, while in ITEM NO. 28 the behavior is totally undesirable.

POOR	GOOD
A poor trainer is overconcerned with misbehavior. He constantly stops training to reprimand the patient.	*Good trainers ignore most bad behaviors unless it becomes necessary to terminate a session if it continues.*

29. Prepares room correctly before training.

The environment in which training occurs is also an important factor to be taken into consideration. If you plan to work on dressing skills it makes sense that you have clothes in the room before you begin, or at least, that you bring them in with the child. It is also important to have whatever props you may need, such as a chair, table, etc. Any distractions should be eliminated if possible.

POOR	GOOD
Poor trainers get the child and then think about what they need. Their rooms are often filled with unnecessary distractions, without the proper rewards, props, etc.	*Good trainers prepare their rooms before beginning, and have the right props, a variety of rewards on hand, and have eliminated as many distractions as possible.*

30. Trains one task at a time.

Retarded patients learn slowly, and it is important for the trainer to be persistent. He may have to work at one skill for a long time before his patient begins to respond properly. For this reason trainers should generally work on one skill at a time, since this increases the patient's chances of success.

POOR	GOOD
Poor trainers skip from one task to another.	*A good trainer works on one task until the child has experienced success.*

GLOSSARY

BEHAVIOR	What a person or animal does. This can range from very small responses or movements like winking your eye to complex responses such as talking.
BRIDGING SIGNAL	A response given by the trainer to "bridge the gap" between giving primary and secondary reinforcement. A bridging signal could be a pat on the back or saying "Good boy."
CONTINGENCY	See REINFORCEMENT CONTINGENCY.
CHAINING	A shaping technique used to teach complex behaviors one component at a time. Each behavioral component can be thought of as a link that makes up the behavioral chain.
ENVIRONMENT	The sum total of all that surrounds us. This includes the physical, social, and personal factors which we come in contact with or which influence us.
EXTINCTION	Undesirable responses are not rewarded or ignored. This is a method of eliminating undesirable behaviors.
GOAL BEHAVIOR	See TARGET BEHAVIOR.
NEGATIVE REINFORCEMENT	A stimulus which a person does not like is presented when the person is behaving in an undesirable manner. This is a method of eliminating undesirable behaviors.
OPERANT BEHAVIOR	Behavior under a person's voluntary control. It is called operant behavior because it operates on the environment to provide us with reinforcement.
OPERANT LEVEL	The level at which a behavior or response is before training.
POSITIVE REINFORCEMENT	A stimulus which the person likes is presented each time the person is behaving in a desirable manner. This is a method to get behavior to occur or to increase the frequency of the behavior which is already present.
PRIMARY REINFORCEMENT	A reward which is unlearned and naturally enjoyable, such as food, drink, and sex.
SECONDARY REINFORCEMENT	A reward which is learned as a result of having been associated with a primary reinforcement. Money, for example, is valuable to us because we can buy food with it.
SHAPING	Molding or developing simple behavior into complex behavior. (See CHAINING and SUCCESSIVE APPROXIMATIONS)

REINFORCEMENT CONTINGENCY	The thing that a person has to do or the behavior he has to emit in order to get a reinforcement. It is the requirement.
REFLEXIVE BEHAVIOR	Behavior not directly under a person's voluntary control, such as sweating, heartbeat, etc.
STIMULUS	Anything in the environment which causes a person to pay attention and emit a response.
STIMULUS CONTROL	Cues or stimuli in the environment which control a person's behavior, make it occur, or indicate the appropriate times for it to occur.
SUCCESSIVE APPROXIMATIONS	A shaping technique used to teach a single behavioral component in a step-by-step manner. The complex behavior is broken down into each succeeding step.
TARGET BEHAVIOR	The behavior which the trainer wants to occur. It is the goal which has been set up in the training program for the patient.

Other sources of definitions for terms used in behavior modification research with the mentally retarded are: Bensberg, G.J. (Ed.) Teaching the mentally retarded: A handbook for ward personnel. Southern Regional Education Board, 1965., and Larsen, L.A., & Bricker, W.A. A manual for parents and teachers of severely and moderately retarded children. IMRID Papers and Reports, 1968, Volume V, No. 22.